HOUSE BILL REPORT
SHB 2165

As Passed House:
February 11, 2014

Title: An act relating to department of early learning fatality reviews.

Brief Description: Concerning department of early learning fatality reviews.

Sponsors: House Committee on Early Learning & Human Services (originally sponsored by Representatives Kagi, Lytton, Morrell, Jinkins and Haigh).

Brief History:
Committee Activity:
Early Learning & Human Services: 1/16/14, 1/20/14, 1/22/14 [DPS].
Floor Activity:
Passed House: 2/11/14, 93-5.

Brief Summary of Substitute Bill

- Requires the Department of Early Learning (DEL) to conduct child fatality reviews for fatalities that occur in a licensed child care center, licensed child care home, or an Early Childhood Education and Assistance Program.
- Outlines procedures for convening a Child Fatality Review Committee, and the selection of committee members.
- Requires the DEL to consult with the Office of the Family and Children's Ombuds to determine if a review should be conducted in the event of a near child fatality.
- Establishes that the DEL and the Child Fatality Review Committee have access to the child care or early learning provider's records that pertain to the child and are relevant to the review.
- Specifies how child fatality review documentation may be used in civil or administrative proceedings and in licensing or disciplinary proceedings.
- Limits how an employee, committee member, or person called as a witness may be examined in civil or administrative proceedings.
- Adds the "Eve Uphold Act" as the short title.

This analysis was prepared by non-partisan legislative staff for the use of legislative members in their deliberations. This analysis is not a part of the legislation nor does it constitute a statement of legislative intent.

Majority Report: The substitute bill be substituted therefor and the substitute bill do pass. Signed by 13 members: Representatives Kagi, Chair; Freeman, Vice Chair; Walsh, Ranking Minority Member; Scott, Assistant Ranking Minority Member; Fagan, Farrell, Goodman, MacEwen, Roberts, Sawyer, Senn, Young and Zeiger.

Staff: Lindsay Lanham (786-7120).

Background:

The Washington State Legislature established the Office of the Family and Children's Ombuds (OFCO) in 1996. Some of the duties of the OFCO include the following: provide information on the rights and responsibilities of individuals receiving family and children services; periodically review the facilities and procedures of state institutions serving children; and recommend procedural changes in addressing the needs of children.

The OFCO also collaborates with the Department of Social and Health Services (DSHS), Children's Administration (CA) to complete child fatality reviews or near child fatality reviews when a fatality is suspected to be caused by child abuse or neglect of any minor in the care of the DSHS or a supervising agency. Child fatality reviews offer a systemic evaluation of the events and circumstances surrounding a fatality or near fatality incident. The CA and the OFCO use the child fatality review process to identify gaps in practice and make improvements to the child welfare system. After the completion of a child fatality review, both the CA and the OFCO issue reports and recommendations to the Legislature.

The Department of Early Learning (DEL) licenses child care centers and family home providers in Washington. Licensing requirements are established by the Legislature and the DEL in rules. The components of the licensure process include child development trainings, first aid and CPR training, criminal background checks, and health and safety checks on child care centers and homes. The purpose of licensing requirements is to promote the health and safety of children attending child care programs.

Currently, the DEL does not complete any child fatality reviews for a fatality or a near fatality that occurs in a licensed child care facility or early learning program.

Summary of Substitute Bill:

The DEL is required to complete child fatality reviews if a child fatality occurs in a licensed child care center, licensed child care home, or an Early Childhood Education and Assistance Program. In completing the reviews, the DEL is required to convene a Child Fatality Review Committee and determine child fatality review committee membership. The Child Fatality Review Committee membership is required to include at least one expert from outside the DEL with knowledge of early learning licensing requirements and program standards. The primary purpose of the fatality review is to develop recommendations to the DEL and the Legislature to strengthen health and safety protection for children. Within 180 days following the fatality, the DEL is required to issue a report to the appropriate committees of the Legislature and publish the reports to a public website.

In the event of a near child fatality, House Bill 2165 (HB 2165) requires the DEL to consult with the OFCO to determine if a review should be conducted.

House Bill 2165 grants the DEL and the Child Fatality Review Committee access to all records and files that have been produced or retained by the child care or early learning provider that pertain to the child and are relevant to the review. House Bill 2165 further specifies that reviews are subject to discovery in a civil or administrative proceeding, but may not be admitted into evidence.

House Bill 2165 establishes that a DEL employee responsible for conducting a child fatality review or near fatality review, or a member of the review Committee may not be examined in a civil or administrative proceeding regarding the following: the work of the Review Committee; the incident under review; committee member statements, deliberations, analyses, or impressions relating to the work of the Review Committee. Additionally, HB 2165 specifies that a person is unavailable as a witness merely because the person was interviewed or provided a statement during a review. If called as a witness, a person may not be examined regarding the person's interactions with the child fatality or near fatality review. House Bill 2165 concludes by specifying that the restrictions outlined do not apply in a licensing or disciplinary proceeding arising from an agency's effort to revoke or suspend a license based in whole or in part upon allegations of wrongdoing in connection with a minor's death or near fatality.

Appropriation: None.

Fiscal Note: Available.

Effective Date: The bill takes effect 90 days after adjournment of the session in which the bill is passed.

Staff Summary of Public Testimony:

(In support) Any child fatality is tragic. House Bill 2165 gives structure and transparency to the work completed by the Department of Early Learning (DEL). Half of the fatalities that occur in licensed child care are related to sudden unexpected infant sleep deaths. The DEL provides information to new parents, new licensees, and licensors about safe sleep. New licensees are also informed about agency rules pertaining to safe sleep practices. The DEL further collaborates with outside experts on safe sleep practices to provide additional support and technical assistance when needed.

A five month old passed away while napping in a family home daycare. Upon further investigation, the parents of the baby discovered that the provider had multiple licensing violations related to sleep practices and supervision concerns. Child Protective Services completed an investigation and the child care provider was found negligent. The provider's license was subsequently revoked. The investigation uncovered that the provider had not followed safe sleep practices and the baby was left unattended for about one hour. If the provider would have followed safe sleep practices and monitored the baby properly, the death could have been prevented.

In 2001 a child passed away in the same family home daycare. The cause of the death was listed as sudden infant death syndrome (SIDS). When contextualizing the experience of the death of his child, one parent offered that he experienced tremendous sadness that would open up and swallow him at any given time. When the family received the diagnosis of SIDS, the family did not challenge the circumstances of the fatality or the child care provider. The family channeled their energy into learning more about SIDS and becoming members of the SIDS community. It was not until the family learned of a second SIDS death in the same home, that they were made aware that there had been an internal review and discovered that there were violations at the facility. The parents assumed that information would have been shared with them; however, no one provided the parents with the information about the rule violations at the daycare.

A mandatory child fatality review is essential to understand what happened, set new policies and procedures, and prevent the loss of another child. It is critical to turn knowledge into power and action to ensure that children are cared for with the utmost regard for their safety.

A child passed away in a child care setting because of unsafe window blind pull cords. The parents assumed the facility was safe because the facility was inspected by trained licensors. Oversight is needed to establish best practices for all providers. Compliance violations should be provided to parents in an easily accessible manner. Parents should have access to child care provider violations. The grief of losing a child stays with a person for life. This law is going help ensure that there are answers and recommendations. This law will help make certain that there is action. A parent offered that our children and our society should flourish without experiencing grief from a child fatality.

A Child Fatality Review is an important form of transparency and the information needs to exist for parents and the community. A Child Fatality Review is also an opportunity to gather information that may help prevent future deaths. A Child Fatality Review may also be of some comfort to a provider, and provide a pathway to advocacy for parents who are experiencing intense grief. If there was an extensive review process, it may also provide parents with a sense that everything that could have been done was completed.

The responsibility of the DEL is oversight and monitoring for the safety of the children. The DEL should only monitor, while providing mentorship to providers should be completed by an independent non-profit organization. House Bill 2165 begins a dialogue about getting parents the information they need to know about the care of their children.

(Neutral) The Children's Administration (CA) is statutorily required to complete child fatality reviews when the death of a child is suspected to be caused by child abuse or neglect and the child was in the care of or receiving services from the CA at the time of death or one year prior to the incident. The purpose of a child fatality review is to increase an agency's understanding of the circumstances around the child's death and to evaluation practice, programs, and systems. The Office of Children and Family Ombuds issues a report after the review, which informs the public on the recommendations and implementation status of recommendations. The DEL is not required to investigate or review fatalities by an external committee, even if there is an allegation of abuse or neglect. This legislation would close that gap. Although the number of child deaths and near child deaths that occur annually in

licensed DEL facilities are very few, these tragedies do occur. Sudden infant death syndrome is a major cause of these fatalities and these are preventable deaths. Child fatality reviews provide opportunities to learn valuable lessons and to improve the health and safety of children.

(Opposed) Remove provisions 4a and 4d as they are designed to protect and shield the DEL managers from being held accountable for not complying with laws and agencies polices. Additionally, remove section 1(d) as it does not create an independent child death fatality review committee. Rather, the provision gives authority to the DEL, an agency with a long documented history of violating child safety rules, to decided who will be on the review committee and what will be seen. Instead, direct the DEL to contact Enterprise Services to facilitate an independent review. Moreover, include language that prohibits managers from participating on review committees and require a law enforcement expert to be on the committee. Mangers should also be required to submit all emails and hand written notes to the Child Fatality Review Committee. There does not need to be a new law because the needed laws are currently in place. However, the managers are not following the laws.

Persons Testifying: (In support) Amy Blondin, Department of Early Learning; Kyle Uphold; Amanda Uphold; Andy Hazzard; Barbara Hazzard; Stu Jacobsen, Washington Parents for Safe Childcare; Michelle Frank; and Larry Frank.

(Neutral) Mary Meinig, Office of the Family and Children's Ombuds.

(Opposed) Margo Logan, Child Care Consulting LLC.

Persons Signed In To Testify But Not Testifying: None.